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TOBY DOUGLAS,
Director, California Department of Health Services,
Petitioner,
v
INDEPENDENT LIVING CENTER
OF SOUTHERN CALIFORNIA, INC., *et al.*, *Respondents*.

TOBY DOUGLAS,
Director, California Department of Health Services,
Petitioner,
v.
CALIFORNIA PHARMACISTS ASSOCIATION, *et al.*, *Respondents*.

TOBY DOUGLAS,
Director, California Department of Health Services,
Petitioner,
v.
SANTA ROSA MEMORIAL HOSPITAL, *et al.*, *Respondents*.

On Writs of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF FORMER HHS OFFICIALS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF *AMICI CURIAE* 1

SUMMARY OF ARGUMENT 2

ARGUMENT 6

I. THE MEDICAID PROGRAM DEPENDS UPON THE ENFORCEABILITY OF § 30(A) 6

II. EXCLUSIVE ENFORCEMENT OF § 30(A) BY HHS IS LOGISTICALLY, PRACTICALLY, LEGALLY, AND POLITICALLY UNFEASIBLE 12

III. PRIVATE ENFORCEMENT OF § 30(A) DOES NOT MATERIALLY INTERFERE WITH THE SECRETARY'S DISCRETION 28

CONCLUSION 35

APPENDIX A-1

TABLE OF AUTHORITIES

CASES

Alaska Dep't of Health & Soc. Servs. v. *CMS*,
424 F.3d 931 (9th Cir. 2005) 31

Ark. Med. Soc'y, Inc. v. *Reynolds*,
6 F.3d 519 (8th Cir. 1993) 10, 16, 32

Arthur C. Logan Mem. Hosp. v. *Toia*,
441 F. Supp. 26 (S.D.N.Y. 1977) 23

Cal. Hosp. Ass'n v. *Obledo*,
602 F.2d 1357 (9th Cir. 1979) 13

Catholic Med. Ctr. of Brooklyn & Queens, Inc. v. *Rockefeller*,
430 F.2d 1297 (2d Cir. 1970) 13

DeGregorio v. *O'Bannon*,
500 F. Supp. 541 (E.D. Pa. 1980) 3, 9

Equal Access for El Paso v. *Hawkins*,
509 F.3d 697 (5th Cir. 2007) 12

Evergreen Presbyterian Ministries Inc. v. *Hood*,
235 F.3d 908 (5th Cir. 2000) 18

Gonzaga Univ. v. *Doe*,
536 U.S. 273 (2002) 12, 17, 23, 28

Harris v. *Olszewski*,
442 F.3d 456 (6th Cir. 2006) 31

Hosp. Ass'n of N.Y. State, Inc. v. *Toia*,
577 F.2d 790 (2d Cir. 1978) 13

Ill. Hosp. Ass'n v. *Edgar*,
765 F. Supp. 1343 (N.D. Ill. 1991) 16

In re NYASHA Litig.,
318 F. Supp. 2d 30 (N.D.N.Y. 2004), *aff'd*,
444 F.3d 147 (2d Cir. 2006) (per curiam) 17

Indep. Living Ctr. of S. Cal., Inc. v. *Shewry*,
543 F.3d 1050 (9th Cir. 2008),
cert. granted sub nom. Maxwell-Jolly v. *Indep. Living Ctr. of S. Cal., Inc.*,
131 S. Ct. 992 (2011) 34

Mass. Gen. Hosp. v. *Weiner*,
569 F.2d 1156 (1st Cir. 1978)..... 13

Minn. Ass'n of Health Care Facilities, Inc. v. *Minn. Dept. of Pub. Welfare*,
602 F.2d 150 (8th Cir. 1979) 13

Nat'l Cable & Telecomms. Ass'n v. *Brand X Internet Servs.*,
545 U.S. 967 (2005) 5, 32

New York v. *Shalala*,
119 F.3d 175 (2d Cir. 1997)..... 5, 32

Opelika Nursing Home, Inc. v. *Richardson*,
323 F. Supp. 1206 (M.D. Ala. 1971)..... 13

Orthopaedic Hosp. v *Belshe*,
103 F.3d 1491 (9th Cir. 1997) 16

Pa. Pharmacists Ass'n v. *Houstoun*,
283 F.3d 531 (3d Cir. 2002) (en banc)..... 17

Pharm. Research & Mfrs. of Am. v. *Thompson*,
362 F.3d 817 (D.C. Cir. 2004)..... 5, 31

S.D. ex rel. Dickson v. *Hood*,
391 F.3d 581 (5th Cir. 2004) 31

St. Mary's Hosp. of E. St. Louis, Inc. v. *Ogilvie*,
496 F.2d 1324 (7th Cir. 1974) 13

Thomas Jefferson Univ. v. *Shalala*,
512 U.S. 504 (1994) 31

United States v. *Mead Corp.*,
533 U.S. 218 (2001) 31

West Virginia v. *Thompson*,
475 F.3d 204 (4th Cir. 2007) 31

Wilder v. *Va. Hosp. Ass'n*,
496 U.S. 498 (1990) ..... passim

FEDERAL STATUTES

42 U.S.C. § 1315(a) 26

42 U.S.C. § 1316(a) 7, 24

42 U.S.C. § 1396a(a)(10)(A)(ii) 8

42 U.S.C. § 1396a(a)(13) 14, 16

42 U.S.C. § 1396a(a)(13)(B) 13

42 U.S.C. § 1396a(a)(30)(A) ..... passim

42 U.S.C. § 1396a(b) 7

42 U.S.C. § 1396c 7, 8, 24

42 U.S.C. § 1396d(b) 7

42 U.S.C. § 1983 ..... 15, 17, 23, 29

Balanced Budget Act of 1997,
Pub. L. No. 105-33, 111 Stat. 251 17

Omnibus Budget Reconciliation Act of 1980,
Pub. L. No. 96-499, 94 Stat. 2599 14

Omnibus Budget Reconciliation Act of 1989,
Pub. L. No. 101-239, 103 Stat. 2106 9

Social Security Amendments of 1965,
Pub. L. No. 89-97, 79 Stat. 286 ..... 6, 8

REGULATIONS AND ADMINISTRATIVE MATERIALS

42 C.F.R. § 430.0 6

42 C.F.R. § 430.15 7

42 C.F.R. § 430.35 8

42 C.F.R. § 433.10(b) 7

42 C.F.R. § 447.204 9

45 C.F.R. § 250.30(a)(5) 3, 9

Medicaid Regulations,
43 FED. REG. 45,176 (Sept. 29, 1978) 9

64 FED. REG. 54,263 (Oct. 6, 1999) 18

Medicaid Program; Methods for Assuring
Access to Covered Medicaid Services,
76 FED. REG. 26,342 (May 6, 2011) 20, 25

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CMS FINANCIAL REPORT: FISCAL YEAR 2008 (2009),
https://www.cms.gov/CFOReport/Downloads/
2008_CMS_Financial_Report.pdf 22

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CMS FINANCIAL REPORT: FISCAL YEAR 2010 (2011),
https://www.cms.gov/CFOReport/Downloads/
2010_CMS_Financial_Report.pdf 22

Medicaid Reimbursement & Finance, CMS.gov,
http://www.cms.gov/MedicaidRF/ 8

LEGISLATIVE MATERIALS

H.R. REP. No. 97-158 (1981) 14, 15

H.R. REP. No. 101-247 (1989),
reprinted in 1989 U.S.C.C.A.N. 2060 ..... 3, 9, 10

H.R. REP. No. 105-149 (1997) 17

Hearing on the Unanimous Bipartisan National Governors Association Agreement on Medicaid,
Hearing Before the House Comm. on Commerce,
104th Cong., 2d Sess. (1996) 11, 30

Medicaid and Welfare Reform,
Hearing Before the S. Comm. on Finance,
104th Cong., 2d Sess. (1996) 18

Medicare and Medicaid,
Hearings Before the S. Comm. on Finance,
91st Cong., 2d Sess. (1970) 6

Medicare and Medicaid Initiatives,
Hearings before the Subcomm. on Health and
the Envt. of the House Comm. on Energy and
Commerce, 101st Cong, 1st Sess. (1989) 10

LEGAL MEMORANDA

Brief for Respondents,
Alaska Dep't of Health & Soc. Servs. v. *CMS*,
424 F.3d 931 (9th Cir. 2005) (No. 04-74204) 18

Brief for the United States as Amicus Curiae
Supporting Petitioner,
Douglas v. *Indep. Living Ctr. of S. Cal., Inc.*,
No. 09-958 (U.S. filed May 26, 2011) .....passim

Brief for the United States as Amicus Curiae
Supporting Petitioners,
Wilder v. *Va. Hosp. Ass'n*,
496 U.S. 498 (1990) (No. 88-2043) 29, 30

Brief of Amicus Curiae Secretary of Health &
Human Services,
Clark v. *Kizer*,
758 F. Supp. 572 (E.D. Cal. 1990) (No. 87-1700).. 25

Statement of Interest of the United States,
Planned Parenthood of Ind., Inc. v.
Comm'r of the Ind. State Dep't of Pub. Health,
No. 11-cv-630 (S.D. Ind. June 16, 2011) 25, 34

United States' Brief as *Amicus Curiae*,
Exeter Mem. Hosp. Ass'n v. *Belshe*,
943 F. Supp. 1239 (E.D. Cal. 1996)
(No. 96-693)..... 16, 24, 33, 34

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Joanna Bisgaier & Karrin V. Rhodes,
Auditing Access to Specialty Care
for Children With Public Insurance,
364 NEW ENG. J. MED. 2324 (2011) 11

Brian J. Dunne,
Comment, *Enforcement of the Medicaid Act Under 42 USC § 1983 After* Gonzaga University v Doe: *The "Dispassionate Lens" Examined*,
74 U. CHI. L. REV. 991 (2007) 23

Michael A. Fletcher,
GOP Governors Push Back Against Obama on Federal Medicaid Rules,
WASH. POST, June 15, 2011, at A1 ..... 26, 27

Denise Grady,
Children on Medicaid Shown To Wait Longer for Care,
N.Y. TIMES, June 15, 2011, at A24 10

Malcolm J. Harkins III,
Be Careful What You Ask For: The Repeal of the Boren Amendment and Continuing Federal Responsibility To Assure that State Medicaid Programs Pay for Cost Effective Quality Nursing Facility Care,
4 J. HEALTH CARE L. & POL'Y 159 (2001) 15

Nicole Huberfeld,
Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements,
42 U.C. DAVIS L. REV. 413 (2008) 20

Jerry L. Mashaw & Dylan S. Calsyn,
Block Grants, Entitlements, and Federalism: A Conceptual Map of Contested Terrain,
14 YALE L. & POL'Y REV. 297 (1996) 27

Edward Alan Miller,
Federal Administrative and Judicial Oversight of Medicaid: Policy Legacies and Tandem Institutions Under the Boren Amendment,
38 PUBLIUS 315 (2008) 15, 18

Abigail R. Moncrieff,
The Supreme Court's Assault on Litigation: Why (and How) It Might Be Good for Health Law,
90 B.U. L. REV. 2323 (2010) 20, 25

Abigail R. Moncrieff,
Comment, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*,
73 U. CHI. L. REV. 673 (2006) 10, 11

Judith M. Rosenberg & David T. Zaring,
Recent Development, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*,
32 HARV. J. ON LEGIS. 545 (1995) 26

PAUL STARR,
THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982) 6

Edward A. Tomlinson & Jerry L. Mashaw,
The Enforcement of Federal Standards in Grant-in-Aid Programs: Suggestions for Beneficiary Involvement,
58 VA. L. REV. 600 (1972) 23

Sidney D. Watson,
Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest,
21 AM. J.L. & MED. 191 (1995) 6, 11

INTRODUCTION

The petition involves the validity of a state law that was only on the books for eight months, and that expired more than a year ago, in February 2009. That state law imposed a ten percent across-the-board reduction to Medicaid rates for providers of medical services and other health care providers, to the detriment of their patients. That state law has been submitted to the federal Department of Health and Human Services for approval, but that process has been stalled by petitioner's failure to respond to the federal government's requests for additional information.

The court of appeals correctly concluded, consistent with the settled practice of this Court and all the regional courts of appeals, that respondents could bring suit in federal court seeking an injunction to bar a state official from enforcing a preempted state law. Such suits give life to the Supremacy Clause.

The court of appeals also correctly concluded that the district court did not abuse its discretion in finding that respondents had established a likelihood of success on the merits of their claim that the federal Medicaid Act preempted the challenged state law. No court in the 45-year history of the Medicaid program has interpreted the Act to allow wholly budget-driven reductions to Medicaid rates without consideration of the effect of the reductions on efficiency, economy, and quality of care, or whether the reduced rates were

congressional intent and would interfere with the Secretary's discretion to administer the Medicaid program. *See* Brief for the United States as Amicus Curiae Supporting Petitioner, *Douglas* v. *Indep. Living Ctr. of S. Cal., Inc.*, No. 09-958 (U.S. filed May 26, 2011) [hereinafter "Gov't Br."].

As *amici* explain below, HHS has never embraced such a view of private enforcement. To the contrary, it has consistently been HHS's position that private enforcement of § 30(A) is not just appropriate, but also necessary to ensure that states comply with this critical regulatory mandate. Nor is there anything to the Justice Department's suggestion that private enforcement would interfere with the Secretary's discretion. As a matter of both historical practice and current law, private enforcement only complements the Secretary's authority.

SUMMARY OF ARGUMENT

Since its inception in 1965, the central purpose of the Medicaid program has been to provide access to "mainstream" health care for those who cannot afford to purchase private medical services. To that end, of

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> A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . .

42 U.S.C. § 1396a(a)(30)(A).

the almost 100 procedural and substantive requirements that the Medicaid Act imposes on state plans, perhaps none is more vital than the "equal access" mandate presently codified in § 30(A), which has its roots in a 1966 HEW Handbook delineating requirements for state Medicaid plans, and a regulation (45 C.F.R. § 250.30(a)(5)) first promulgated by HEW in 1971. *See DeGregorio* v. *O'Bannon*, 500 F. Supp. 541, 549 & n.13 (E.D. Pa. 1980). And as § 30(A)'s legislative history makes clear, the equal access provision exists to ensure that providers will not refuse to treat Medicaid beneficiaries due to inadequate state reimbursement rates. *See, e.g.*, H.R. REP. NO. 101-247, at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 2060, 2116. After all, without meaningful enforcement of the equal access provision, states would have little incentive to reimburse providers at mainstream rates, and providers would in turn have little incentive to treat Medicaid beneficiaries.

Despite its agreement with these basic principles, the Justice Department's *amicus* brief maintains that private enforcement of the equal access provision is inconsistent with the statutory scheme, implicitly suggesting that Congress intended for the provision to be enforced exclusively by HHS. *See, e.g.*, Gov't Br., *supra*, at 12. But exclusive administrative enforcement of § 30(A) is logistically, practically, legally, and politically unfeasible. First, because the Medicaid Act contemplated—and has historically been understood to allow—direct redress by beneficiaries, neither CMS nor HHS has the resources to provide comprehensive oversight of state-by-state compliance with the equal access provision. Second, because funds for the

administration of Medicaid are provided by appropriation, they are subject to far greater congressional budget constraints than Medicaid benefits. Third, as CMS itself has repeatedly conceded, it is limited both practically and legally in its authority to both enforce § 30(A) and provide remedies for violations thereof. Fourth, and finally, even in the absence of such constraints, the "cooperative federalism" behind Medicaid means that the Executive Branch is under far more political pressure from states than from private parties.

None of these points are unique to the equal access mandate—or to the Medicaid Act more generally. But taken together, they reinforce the general proposition that the federal government lacks the financial, legal, logistical, and political wherewithal comprehensively to enforce § 30(A) against the states. Thus, whereas the Department of Justice suggests that "Recognition of a nonstatutory cause of action for Medicaid providers and beneficiaries in this setting would be in tension with the nature of the federal-state relationship and the enforcement scheme contemplated by the statute," Gov't Br., *supra*, at 25, the reality is that *exclusive* federal enforcement would be in far greater tension with the scheme Congress intended and HHS has historically supported and embraced, if for no other reason than that it would not—and probably cannot—produce meaningful compliance with the Medicaid Act's access mandate.

In the alternative, the Justice Department's *amicus* brief suggests that private enforcement of the equal access provision would interfere with the Secretary's discretion in administering the Medicaid program. *See* Gov't Br., *supra*, at 32. The federal

government has never previously opposed private enforcement of the equal access provision on the ground that it would interfere with the Secretary's authority to administer the Medicaid program. In cases in which § 30(A) is ambiguous, the Secretary's reasonable interpretation thereof will generally be entitled to *Chevron* deference. *See, e.g.*, *Pharm. Research & Mfrs. of Am.* v. *Thompson*, 362 F.3d 817, 821–22 (D.C. Cir. 2004). As a result, she would not be bound by prior judicial decisions holding that particular state plan amendments do or do not violate § 30(A) in cases in which the statute is held to be ambiguous. *See Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 982 (2005).

Moreover, a judicial decision upholding or invalidating a state plan amendment based upon an interpretation of ambiguous language within § 30(A) would not preclude the state from submitting either that amendment or a revised one to the Secretary for approval. *See, e.g.*, *New York* v. *Shalala*, 119 F.3d 175, 180–81 (2d Cir. 1997). Private enforcement therefore provides a means for meaningful statutory enforcement both until and unless the Secretary has the opportunity to exercise her discretion, and to ensure that the Secretary is acting within her discretion. Ultimately, then, private enforcement may even expand the Secretary's discretion by providing a means of ensuring state compliance with the equal access mandate that is far less draconian than the specific remedies directly available to the Secretary. This understanding has been the cornerstone of HHS policy throughout the history of the Medicaid Act, and remains the prevailing view of those charged with administering the program.

ARGUMENT

I. THE MEDICAID PROGRAM DEPENDS UPON THE ENFORCEABILITY OF § 30(A)

a. The Central Purpose of Medicaid is To Provide Access to "Mainstream" Health Care for Those Who Cannot Afford Private Medical Services

In the Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, Congress created the Medicare and Medicaid programs with the express goal of providing "mainstream" health care services for those individuals unlikely to have access to such services on the private market—including children, the elderly, those with certain disabilities, and the poor. *See, e.g.*, *Medicare and Medicaid*, Hearings Before the S. Comm. on Finance, 91st Cong., 2d Sess., pt. I, at 57 (1970) (statement of Hon. John G. Veneman, Under-Secretary, Department of Health, Education, and Welfare); *see also* 42 C.F.R. § 430.0 (2011) (describing purpose of the Medicaid program).

Medicaid was specifically designed to eliminate—or at least ameliorate—the "dual-track" system then in effect, pursuant to which those of means received medical care from private physicians, whereas those who could not afford such treatment received care in ambulatory clinics and emergency rooms, if at all. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 151–52 (1982); Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 192–93 (1995). Thus, it is no overstatement to suggest that meaningful access to mainstream medical services is the linchpin of the Medicaid regime.

Congress sought to effectuate this access goal by authorizing open-ended federal grants to states subject to a series of complex and interlocking procedural and substantive conditions. In short, states that choose to participate (as all have)[4] must submit a detailed "plan for medical assistance" that comprehensively outlines the nature and scope of the state's Medicaid program. If that plan is approved, the state becomes entitled under the Medicaid Act to "reimbursement" of a substantial percentage of its outlays (the "FFP," or federal financial participation), which varies based on state economic circumstances between the statutory floor (50%) and ceiling (83%). *See* 42 U.S.C. § 1396d(b); 42 C.F.R. § 433.10(b) (2011). *See generally Wilder* v. *Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990) (describing the structure of the Medicaid program).

As a result of this statutory structure, the Secretary of HHS has two direct means of ensuring state compliance with the Medicaid Act's procedural and substantive requirements: She must decline to approve state plans (or amendments thereto) ex ante, including amendments that change reimbursement policies, if they fail to comport with the Act or with regulations promulgated under it. *See* 42 U.S.C. §§ 1396a(b), 1396c; 42 C.F.R. § 430.15. And even if the plan or the relevant amendment thereto has been approved, she may also initiate an ex post "compliance" proceeding pursuant to 42 U.S.C. § 1316(a) if the state plan either on its face or as applied no longer complies with the Act. The

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4. Including the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, there are 56 different jurisdictions currently participating in the Medicaid program.

compliance proceeding in turn could produce termination of FFP either for entire categories of state assistance, or, in the extreme, for the entire state Medicaid program. *See* 42 U.S.C. § 1396c; 42 C.F.R. § 430.35.

b. Section 30(A) Exists To Ensure that Providers Will Not Refuse To Treat Medicaid Beneficiaries Due To Inadequate Reimbursement Rates

Of the almost 100 procedural and substantive requirements that the Medicaid Act imposes on state plans, perhaps none is more central to Medicaid's access-oriented goal than the "equal access" mandate presently codified in § 30(A).[5] Although the equal access language did not appear in the original text of the Medicaid Act, Congress did initially require state Medicaid plans to "provide that the medical assistance made available to individuals receiving aid or assistance under any such State plan . . . shall not be less in amount, duration, or scope than the medical or remedial care or services made available to individuals not receiving aid or assistance under any such plan." Social Security Amendments of 1965, § 121(a), 79 Stat. at 345 (formerly codified at 42 U.S.C. § 1396a(a)(10)(A)(ii)).

To that end, since immediately after the enactment of the Medicaid Act, HEW (and later

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5. Even the CMS website provides in the first sentence of its "Overview" of state plan reimbursement that "CMS reviews State plan amendment reimbursement methodologies for services provided under the State plan for consistency with Section 1902(a)(30)(A) of the Social Security Act (the Act) and *other* applicable federal statutes and regulations." Medicaid Reimbursement & Finance, CMS.gov, http://www.cms.gov/MedicaidRF/ (emphasis added).

HHS) interpreted the statute to require that states maintain adequate reimbursement levels for covered services. *See* 42 C.F.R. § 447.204 (2011) ("The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population."). While § 447.204 itself was not promulgated until 1978, its roots date back to a 1966 HEW Handbook delineating requirements for state Medicaid plans, and to a regulation (45 C.F.R. § 250.30(a)(5)) first promulgated in 1971. *See DeGregorio* v. *O'Bannon*, 500 F. Supp. 541, 549 & n.13 (E.D. Pa. 1980) (tracing this evolution); *see also* Medicaid Regulations, 43 FED. REG. 45,176, 45,258 (Sept. 29, 1978).

Nevertheless, worried that the regulatory equal access mandate was being under-enforced, Congress in 1989 went one step further, formally codifying the equal access language in § 30(A) as part of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(a), 103 Stat. 2106, 2260. As the authoritative House Budget Committee Report accompanying the Act noted,

> The Committee recognizes that payment levels are only one determinant of physician participation [in Medicaid]. However, the Committee believes that, without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program . . . .

H.R. REP. NO. 101-247, at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 2060, 2116. *See generally Ark. Med. Soc'y, Inc.* v. *Reynolds*, 6 F.3d 519, 526 (8th Cir.

1993) (discussing the purpose and significance of the 1989 amendment to § 30(A)).

Congress in 1989 thereby made explicit what HEW and HHS had assumed since 1966: to vindicate its central goal, the Medicaid program requires that states reimburse providers at reasonable rates—not because beneficiaries should be entitled to dollar-for-dollar parity in the funding of their health care, but because they are entitled by statute to equal access to *providers*, virtually none of whom would participate in Medicaid if they would only be reimbursed at inadequate levels. *See* Abigail R. Moncrieff, Comment, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 686 (2006) [hereinafter "Moncrieff, *Interpreting the "Equal Access" Provision*"].

Indeed, the 1989 amendment to § 30(A) was prompted by the jointly shared sentiment expressed by the National Governors Association, Congress, and HHS that the Medicaid Act had not yet succeeded in eliminating the "dual-track" system that had prompted the program in the first place. *See* H.R. REP. NO. 101-247, at 390, *reprinted in* 1989 U.S.C.C.A.N. at 2116; *see also Medicare and Medicaid Initiatives*, Hearings before the Subcomm. on Health and the Envt. of the House Comm. on Energy and Commerce, 101st Cong, 1st Sess. 108 (1989) (statement of Richard N. Jensen, National Governors' Association).

Inasmuch as one could offer a comparable critique today, *see, e.g.*, Denise Grady, *Children on Medicaid Shown To Wait Longer for Care*, N.Y. TIMES, June 15, 2011, at A24 (citing Joanna Bisgaier & Karrin V. Rhodes, *Auditing Access to Specialty Care for Children With Public Insurance*, 364 NEW ENG. J.

MED. 2324 (2011)), two points nevertheless bear mention: First, the 1989 amendment *has* helped. *See, e.g.*, Watson, *supra*, at 200 (noting a fifteen-percent increase in state reimbursement rates for physicians in the first few years after the amendment).

Second, and in any event, Congress in 1989 underscored the extent to which the central purpose of the Medicaid program would be jeopardized without equal access, since states would otherwise have little incentive to set reimbursement rates at market levels, and providers, in turn, would have little incentive to offer services at the resulting reimbursement rates. *See* Moncrieff, *Interpreting the Equal Access Provision*, *supra*, at 686 ("Although it would be controversial to claim that § 30(A) requires rate parity, the provision's legislative history indicates that Congress intended to require a closer relationship between Medicaid rates and private-market rates than existed in 1989." (footnote omitted)).

To that end, the goal of the 1989 amendment was not merely to codify the equal access mandate in the abstract, but, in the process, to make it more likely that the mandate would be meaningfully enforced. As Secretary Shalala testified before the House Commerce Committee in 1996, "[i]mplicit in the concept of defined populations and defined benefits is the notion of a meaningful enforcement mechanism." *Hearing on the Unanimous Bipartisan National Governors Association Agreement on Medicaid*, Hearing Before the House Comm. on Commerce, 104th Cong., 2d Sess. (1996) (statement of Hon. Donna E. Shalala) [hereinafter "*NGA Agreement* Hearing"].

II. EXCLUSIVE ENFORCEMENT OF § 30(A) BY HHS IS LOGISTICALLY, PRACTICALLY, LEGALLY, AND POLITICALLY UNFEASIBLE

In its *amicus* brief in support of the Petitioner, the Justice Department does not dispute any of the above. Nor does it question the signal importance of the equal access mandate to the Medicaid program more generally. *See, e.g.*, Gov't Br., *supra*, at 12 ("It is essential under [§ 30(A)] that States carefully consider what impact payment rate changes may have on the availability of providers sufficient to furnish covered care and services to Medicaid beneficiaries.").

What the brief neglects, though, is both the well-established history of the Medicaid Act (within which private enforcement has figured prominently in ensuring adherence to the equal access mandate), and the extent to which that history has influenced the federal government's direct enforcement ability. And notwithstanding that this history has been given short shrift by lower-court decisions concerning the private enforceability of § 30(A) after *Gonzaga University* v. *Doe*, 536 U.S. 273 (2002), *see, e.g.*, *Equal Access for El Paso* v. *Hawkins*, 509 F.3d 697 (5th Cir. 2007), the fact remains that both the history and present structure of the Medicaid program stand in marked contrast to the arguments offered by the Justice Department in this case.

a. Private Enforcement of § 30(A) Is Wholly Consistent With the Structure and History of the Medicaid Act

Under the Medicaid Act as initially enacted, there was no question that the statute contemplated tandem enforcement of the Act's central procedural

and substantive requirements by the Secretary and by private plaintiffs—including providers and beneficiaries. As testament to that understanding, dozens of suits were brought during the first 15 years under the Medicaid program in which private litigants sought to enforce those provisions requiring states to reimburse providers on a "reasonable cost related basis," such as § 13(B) (as amended in 1972).[6]

Section 30(A) itself was not originally subject to private enforcement, but that was because at the time, it imposed a ceiling on reimbursement rates, and not a floor, *see, e.g.*, *Opelika Nursing Home, Inc.* v. *Richardson*, 323 F. Supp. 1206, 1210–11 (M.D. Ala. 1971), and not because private enforcement was in any way disfavored. To the contrary, suits in which beneficiaries and providers sought to enforce the floor imposed by the "reasonable cost" provisions were legion, *see Wilder*, 496 U.S. at 516 & n.14 (noting examples), even as searching federal review of state plans expanded. Thus, "it is clear that prior to the passage of the Boren Amendment, Congress intended that health care providers be able to sue in federal court for injunctive relief to ensure that they were reimbursed according to reasonable rates." *Id.* at 516. And as the *Wilder* Court emphasized, HEW policy throughout the 1970s reflected (and supported) this view of the availability and utility of concurrent

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6. For exemplar cases, see *Cal. Hosp. Ass'n* v. *Obledo*, 602 F.2d 1357, 1358 (9th Cir. 1979); *Minn. Ass'n of Health Care Facilities, Inc.* v. *Minn. Dept. of Pub. Welfare*, 602 F.2d 150, 152 (8th Cir. 1979); *Hosp. Ass'n of N.Y. State, Inc.* v. *Toia*, 577 F.2d 790, 792 (2d Cir. 1978); *Mass. Gen. Hosp.* v. *Weiner*, 569 F.2d 1156, 1157 (1st Cir. 1978); *St. Mary's Hosp. of E. St. Louis, Inc.* v. *Ogilvie*, 496 F.2d 1324, 1326–28 (7th Cir. 1974); and *Catholic Med. Ctr. of Brooklyn & Queens, Inc.* v. *Rockefeller*, 430 F.2d 1297, 1298 (2d Cir. 1970).

enforcement. *See id.* at 518 n.15 (citing legislative testimony and other official agency statements).

Largely in response to the increase in both private litigation and federal administrative oversight, Congress altered the status quo in 1980 by enacting the Boren Amendment, Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, § 962(a), 94 Stat. 2599, 2650–51 (formerly codified at 42 U.S.C. § 1396a(a)(13)).[7] The Boren Amendment, along with additional provisions enacted in 1981, rewrote § 13 of the Medicaid Act with the general goal of providing greater flexibility to the states to set payments for inpatient services. *See* H.R. REP. NO. 97-158, at 293 (1981). *See generally* Malcolm J. Harkins III, *Be Careful What You Ask For: The*

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7. In pertinent part, the Boren Amendment rewrote § 13(A) to provide that:

> [A] State plan for medical assistance must . . . provide . . . for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded . . . through the use of rates (determined in accordance with the methods and standards developed by the State . . .) *which the State finds, and makes assurances satisfactory to the Secretary*, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality . . . .

42 U.S.C. § 1396a(a)(13)(A) (1981) (emphasis added).

Repeal of the Boren Amendment and Continuing Federal Responsibility To Assure that State Medicaid Programs Pay for Cost Effective Quality Nursing Facility Care, 4 J. HEALTH CARE L. & POL'Y 159, 168–78 (2001) (summarizing the Boren Amendment's origins and legislative history).

At its core, the Boren Amendment "transferred to the states the primary authority and responsibility, previously exercised by [HHS] for determining and assuring that Medicaid payment rates complied with the substantive standards of the Medicaid Act." Harkins, *supra*, at 159. And yet, although Congress thereby intended to minimize the federal government's role in ensuring that state plans complied with certain aspects of the Medicaid Act, the legislative history was just as clear that Congress meant for private judicial enforcement to remain as the backstop. As the House Budget Committee concluded, "Of course, in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action." H.R. REP. NO. 97-158, at 301; *see also* Edward Alan Miller, *Federal Administrative and Judicial Oversight of Medicaid: Policy Legacies and Tandem Institutions Under the Boren Amendment*, 38 PUBLIUS 315, 321–26 (2008) (summarizing the widespread private judicial enforcement of the Boren Amendment and its effects).

This Court relied on that understanding in *Wilder*, which held that the language of the Boren Amendment and its history manifested a clear congressional intent to create a substantive federal right privately enforceable by health care providers via 42 U.S.C. § 1983. *See* 496 U.S. at 512–20.

Although *Wilder* concerned only § 13 of the Medicaid Act, the Court's analysis is telling here for two distinct—but related—reasons. First, the Court reaffirmed the relationship between private suits and state adherence to the Medicaid Act's substantive standards. *See, e.g., id.* at 515 ("In passing the Boren Amendment, Congress sought to decentralize the method for determining rates, but not to eliminate a State's fundamental obligation to pay reasonable rates."). Second, because the "equal access" language codified in 1989 was designed with the Boren Amendment very much in mind, courts viewed the private enforceability of § 30(A) as following from *Wilder*'s analysis of § 13. *See, e.g., Orthopaedic Hosp.* v *Belshe*, 103 F.3d 1491, 1498–99 (9th Cir. 1997); *Ark. Med. Soc'y*, 6 F.3d at 525–28; *see also Ill. Hosp. Ass'n* v. *Edgar*, 765 F. Supp. 1343, 1349 (N.D. Ill. 1991) ("Section 1396a(a)(30) appears to complement the Boren Amendment . . . .").

Wilder's reading of the Boren Amendment thereby reinforced what had consistently been HHS's position: whatever degree of oversight the Secretary was supposed to exercise over state plans, private enforcement remained the safety valve for ensuring state adherence to the rate minima within the Medicaid Act, including the "equal access" language in § 30(A). *See, e.g.*, United States' Brief as *Amicus Curiae* at 8, *Exeter Mem. Hosp. Ass'n* v. *Belshe*, 943 F. Supp. 1239 (E.D. Cal. 1996) (No. 96-693) [hereinafter *"Exeter* Amicus Br."] ("Under [*Wilder*] and its progeny, a State that implements a pending [plan amendment] assumes the risk that, in addition to actions that HCFA may take, providers may bring suit challenging the State's payment rates or seeking to enjoin the State's implementation of the

[amendment] for failure to comply with the substantive or procedural requirements of the statute and regulations." (citation omitted)).

To be sure, when Congress repealed the Boren Amendment in the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711, 111 Stat. 251, 507–08, some of the legislative history reflected hostility to such private enforcement. *See, e.g.*, H.R. REP. NO. 105-149, at 591 (1997) ("It is the Committee's intention that, following enactment of this Act, neither this nor any other provision of [§ 1396] will be interpreted as establishing a cause of action for *hospitals and nursing facilities* relative to the adequacy of the rates they receive." (emphasis added)).

But even if this legislative history could govern given the absence of statutory text to that effect, *see, e.g.*, *In re NYASHA Litig.*, 318 F. Supp. 2d 30, 32 (N.D.N.Y. 2004) (noting that § 30(A) "was not affected by repeal of the Boren Amendment"), *aff'd*, 444 F.3d 147 (2d Cir. 2006) (per curiam), Congress nevertheless left intact private suits by *other* providers (the Medicaid Act identifies almost two dozen classes of eligible providers besides nursing homes and hospitals), and, more fundamentally, by beneficiaries. To that end, pre-*Gonzaga* case law barring providers from enforcing § 30(A) via § 1983 turned on the assumption that beneficiaries could still sue after the repeal of the Boren Amendment—indeed, that the availability of beneficiary suits rendered provider suits superfluous. *See, e.g.*, *Pa. Pharmacists Ass'n* v. *Houstoun*, 283 F.3d 531, 543–44 (3d Cir. 2002) (en banc) (Alito, J.) ("Not only is HHS responsible for ensuring that state plans are administered in accordance with these requirements,

but Medicaid recipients plainly satisfy the intended-to-benefit requirement and are thus potential private plaintiffs." (citation omitted)); *see also Evergreen Presbyterian Ministries Inc.* v. *Hood*, 235 F.3d 908, 928–29 & n.26 (5th Cir. 2000).

HHS took a similar view at the time, *see, e.g.*, *Medicaid and Welfare Reform*, Hearing Before the S. Comm. on Finance, 104th Cong., 2d Sess. (1996) (statement of Hon. Donna E. Shalala) (suggesting that repealing the Boren Amendment "resolves states' concern about their exposure to providers' suits in Federal court, and does not undermine beneficiaries' ability to enforce their Federal guarantee to coverage and benefits"),[8] and has continued to adhere thereto, *see, e.g.*, Brief for Respondents at 36, *Alaska Dep't of Health & Soc. Servs.* v. *CMS*, 424 F.3d 931 (9th Cir. 2005) (No. 04-74204) (advancing CMS's position that the repeal of the Boren Amendment did not affect the meaning or enforceability of § 30(A)).

b. As a Result, Neither CMS Nor HHS Has the Resources To Provide

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8. In addition to Secretary Shalala's testimony, HCFA in 1999 proposed a new rule that would have based plan amendment approval "on simple assurances that a public process had been used when adopting reimbursement policy changes," Miller, *supra*, at 328, all-but conceding that private litigation—rather than rigorous administrative oversight—had become the principal means for enforcing § 30(A). *See* 64 FED. REG. 54,263 (Oct. 6, 1999); *see also* Miller, *supra*, at 328 (citing a 1997 letter by Sally Richardson, HCFA's Director of the Center for Medicaid and State Operations, for the proposition that "HCFA sought to minimize its role in reviewing state plan amendments governing reimbursement beyond even the minimal standards established by Boren," resulting in that much more of a focus on private enforcement).

Comprehensive Oversight of State-by-State Compliance With § 30(A)

Although the above history demonstrates the extent to which both Congress and HHS have always viewed private enforcement (by beneficiaries, at a minimum) as key to the Medicaid regime, the history matters for a separate, but equally important, reason: *Because* private enforcement was historically available under the Medicaid Act, HHS was never faced with the specter of exclusive enforcement authority, and could instead rely on the availability of private enforcement to supplement—if not supplant—its own responsibilities. Thus, fewer than 500 federal employees are today tasked with supervising 56 different Medicaid programs administering nearly $400 billion in federal funds every year. Out of necessity, most of those employees are concerned with bookkeeping and routine financial management of Medicaid funds at the state level, and not with reviewing state plans and plan amendments for compliance with § 30(A).

Indeed, as Professor Moncrieff has explained, partly *because* private enforcement was routinely available (and championed by HEW and HHS), the government has itself never aggressively sought to enforce the equal access mandate, or to obtain the necessary financial and administrative resources to do so. Instead,

> CMS tends to rubber-stamp state plans and to pass the buck to state agencies when providers and beneficiaries complain. In fact, CMS directs more of its Medicaid resources to policing individual providers' compliance with Medicaid fraud and abuse laws than

> policing state agencies' compliance with the federal statute. On the occasions that CMS does reject state plans or insist on amendments thereto, it almost always does so to protect its own funds from perceived state raids.

Abigail R. Moncrieff, *The Supreme Court's Assault on Litigation: Why (and How) It Might Be Good for Health Law*, 90 B.U. L. REV. 2323, 2340–41 (2010) [hereinafter "Moncrieff, *Assault on Litigation*"] (footnotes omitted); *see also* Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 466 (2008) (documenting CMS's focus on fraud prevention in lieu of access enforcement).[9]

Even a proposed new CMS rule interpreting § 30(A) recognizes the inability of CMS to provide for comprehensive enforcement. Thus, the new rule would require states to conduct their *own* periodic "access reviews," and to submit the results of such reviews "prior to submission of a [plan amendment] to reduce rates or alter the structure of provider payment rates in circumstances that could result in access issues for a covered service." Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 FED. REG. 26,342, 26,345 (May 6, 2011). Moreover, the new rule would allow states

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9. In addition, "CMS has never developed a robust administrative remedy for individuals wanting to challenge CMS approval of Medicaid plans. Although some administrative processes exist for raising challenges to Medicaid plans, including challenges to reimbursement rates, Medicaid's administrative process (unlike Medicare's) has never been an effective means of enforcing the federal statute." Moncrieff, *Assault on Litigation*, *supra*, at 2341 (footnotes omitted).

to avoid compliance actions by developing their own "corrective action plans" when access issues are identified, which CMS "would not treat . . . as a finding of non-compliance, but as evidence of a good faith effort by the State to remain in compliance." *Id.* at 26,347. If CMS had the resources to provide for such oversight at the federal level, the provision of such fox-guarding-the-henhouse incentives to states to self-monitor would hardly be necessary.

c. Because Funds for the Administration of Medicaid are Provided by Appropriation, They Are Subject to Far Greater Congressional Budget Constraints

Even if CMS preferred to prioritize federal enforcement of the equal access mandate, it would encounter the additional hurdle that its enforcement budget—unlike the reimbursements that comprise FFP—must be appropriated on an annual basis. Under current budgetary rules, the administrative expenses of Medicare and Medicaid, like some but not all federal social insurance programs, are classified as "discretionary" spending, in contrast to funding of Medicaid *services*, which is classified as "mandatory" spending.

As a result, CMS must request funds annually to administer Medicaid, competing with the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, and other HHS agencies that typically are far more popular subjects of legislative munificence. Thus, according to CMS's own certified report, the funds available for federal administration of Medicaid during the most recent fiscal year totaled roughly $141 million (less than $2.10 per beneficiary),

whereas total program outlays totaled $382 billion. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., CMS FINANCIAL REPORT: FISCAL YEAR 2010, at 8, 52 (2011), https://www.cms.gov/CFOReport/Downloads/2010_CMS_Financial_Report.pdf. In other words, administrative expenses represented less than four-hundredths of one percent of total program costs.

As the CMS reports indicate, for most of the last two decades, program outlays have grown at a proportionately—as well as absolutely—higher rate than administrative budgets.[10] Thus, even if CMS made increased administrative enforcement of § 30(A) (to say nothing of the rest of the Medicaid Act) a priority, the reality of the current budget deficit renders it unlikely that the agency would be able to expand its enforcement ability.

d. CMS is Limited Both Practically and Legally in its Authority To Enforce § 30(A) and To Provide Remedies for Violations Thereof

At a more fundamental level, though, the principal obstacle to meaningful federal enforcement of the equal access mandate is neither logistical nor financial, but practical. As is true of any federal grant-in-aid program, "the posture of the federal agency toward its grantees is not generally that of a referee calling fouls, but that of a coach giving support in the form of cash and expertise." Edward A. Tomlinson & Jerry L. Mashaw, *The Enforcement*

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10. Over the last three years alone, expenditures for Medicaid administration *declined* by 44%, from $253 million for FY2008. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., CMS FINANCIAL REPORT: FISCAL YEAR 2008, at 46 (2009), https://www.cms.gov/CFOReport/Downloads/2008_CMS_Financial_Report.pdf.

of Federal Standards in Grant-in-Aid Programs: Suggestions for Beneficiary Involvement, 58 VA. L. REV. 600, 620 (1972).

Medicaid is hardly unique in this regard, but "[t]his general reluctance by federal agencies to police states by withholding program funding is particularly acute in the Medicaid context, where massive budget overruns in state programs are almost a matter of course and states are politically 'locked-in' to [FFP]." Brian J. Dunne, Comment, *Enforcement of the Medicaid Act Under 42 USC § 1983 After* Gonzaga University v Doe*: The "Dispassionate Lens" Examined*, 74 U. CHI. L. REV. 991, 994–95 (2007); *cf. Arthur C. Logan Mem. Hosp.* v. *Toia*, 441 F. Supp. 26, 27 (S.D.N.Y. 1977) ("The Secretary can withhold payment or he can negotiate with a State. He cannot compel compliance.").

Further to that end, HHS itself has been quite candid about its unwillingness to pursue the more drastic legal remedies with which Congress has provided it:

> A compliance action, which results in the withholding of FFP, has a potentially detrimental effect on Medicaid recipients and providers. If HCFA were to withhold FFP pursuant to a compliance action, recipients may well be deprived of medical assistance because the State may no longer be able to provide certain services. Particularly where a pending [plan amendment] involves the expansion of Medicaid services, a compliance action can deprive recipients of those expanded services. Thus, before exercising its

> discretionary authority to initiate a formal compliance action against a State, HCFA carefully weighs the advantages and disadvantages.

Exeter Amicus Br., *supra*, at 13 n.11.

Also relevant is CMS's disinclination to initiate compliance actions *while* state plan amendments are pending. *See, e.g., id.* at 11 ("HCFA does not generally initiate a compliance action against a State that implements a [plan amendment] prior to HCFA approval during the period that the agency is reviewing the [amendment], whether before or following a request for additional information."). Given the agency's limited litigation resources, it has long adhered to the "general rule" that it "does not generally expand the resources necessary to pursue a compliance action against a State where HCFA might ultimately approve the [plan amendment] at issue." *Id.* at 12.

Taken together with the extensive administrative and judicial review that findings of non-compliance and denials of plan amendments both typically precipitate,[11] the practical result is that there is almost always a substantial period of time during which HHS can take no administrative action to

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11. After either a denial of a proposed plan amendment or an administrative finding of non-compliance, the state has a statutory right to a full administrative hearing, the final decision in which may in turn be reviewed by the relevant U.S. Court of Appeals pursuant to the Administrative Procedure Act. *See* 42 U.S.C. §§ 1316(a), 1396c. For exemplar cases, see *Iowa Dep't of Hum. Servs.* v. *CMS*, 576 F.3d 885 (8th Cir. 2009); *Md. Dep't of Health & Mental Hygiene* v. *CMS*, 542 F.3d 424 (4th Cir. 2008); *Minnesota* v. *CMS*, 495 F.3d 991 (8th Cir. 2007); and *La. Dep't of Health & Hosps.* v. *CMS*, 346 F.3d 571 (5th Cir. 2003).

remedy an ongoing violation of § 30(A). *See, e.g.*, Statement of Interest of the United States at 1–3, *Planned Parenthood of Ind., Inc.* v. *Comm'r of the Ind. State Dep't of Pub. Health*, No. 11-cv-630 (S.D. Ind. June 16, 2011) [hereinafter "*Planned Parenthood* Amicus Br."] (explaining why injunctive relief is both necessary and appropriate to prevent a state from continuing to violate the Medicaid Act until HHS has the opportunity formally to reject a plan amendment).

Not surprisingly, then, "HHS has long recognized that access issues are not easily resolved in formal or adjudicatory settings." Brief of Amicus Curiae Secretary of Health & Human Services at 12, *Clark* v. *Kizer*, 758 F. Supp. 572 (E.D. Cal. 1990) (No. 87-1700). Instead, "HHS regional officials have sought to monitor and promote access through informal processes, principally by raising the issue of the adequacy of rates in meetings and correspondence with state authorities." *Id.* The proposed new CMS rule reflects this approach, since it aims to create new means of promoting adherence to § 30(A) short of federal disapproval or compliance proceedings. *See* 76 FED. REG. at 26,345.

Finally, it bears noting that there is no realistic financial incentive for CMS aggressively to enforce § 30(A)—quite to the contrary. Because FFP is a function of the funds the state *actually* expends reimbursing providers, state non-compliance with § 30(A) necessarily results in lower reimbursement rates, thereby saving the federal government money. *See* Moncrieff, *Assault on Litigation*, *supra*, at 2341 ("In that framework, CMS is unlikely to enforce something like the Equal Access Provision, which would, in its violation, save federal money."). If

anything, because poorer states tend to have the highest percentage of their Medicaid outlays reimbursed by the federal government, the states under the greatest pressure to cut costs will be those in which the federal government spends (and stands comparatively to save) the highest proportion of funds.

e. Even in the Absence of Such Constraints, the "Cooperative Federalism" Behind Medicaid Means That the Executive Branch is Under Far More Political Pressure from States than From Beneficiaries or Providers

Aside from the specific logistical and practical hurdles that CMS would face if it sought aggressively to enforce the equal access mandate, political considerations also suggest that exclusive federal enforcement is unlikely to vindicate the Medicaid Act's access-oriented goal. Under the Medicaid Act, the only permissible way to reduce reimbursements across the board is to tighten eligibility requirements—a measure that itself requires the permission of the federal government. *See* 42 U.S.C. § 1315(a); Judith M. Rosenberg & David T. Zaring, Recent Development, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545 (1995).

As news reports suggest, Arizona and New Jersey have recently made such requests based on current economic conditions, and similar efforts from other states are likely in the offing. *See* Michael A. Fletcher, *GOP Governors Push Back Against Obama on Federal Medicaid Rules*, WASH. POST, June 15, 2011, at A1. And whatever else may be true about

the politically partisan nature of many of these bilateral state-federal negotiations, *see, e.g.*, *id.*, what cannot be gainsaid is that neither providers nor Medicaid beneficiaries have a seat at the table in these discussions, or any means of legally contesting arrangements that are reached therein.

Again, this reality is hardly specific to the Medicaid program. The intended beneficiaries of federal funds are usually underrepresented when it comes to federal-state interactions with regard to program administration. *See generally* Jerry L. Mashaw & Dylan S. Calsyn, *Block Grants, Entitlements, and Federalism: A Conceptual Map of Contested Terrain*, 14 YALE L. & POL'Y REV. 297 (1996). But given that Medicaid consumed nearly 22 percent of all state budgets (including FFP) in FY2010, and as much as 37 percent of some, *see* Fletcher, *supra*, there is every reason to believe that the political pressure the federal government receives from the states will be at its zenith in the Medicaid context, all the more so in light of the absence of comparable pressure to enforce zealously those statutory mandates that compel states (and the federal government) to spend *more* money.

* * *

On their own, none of the above points are unique to the equal access mandate—or to the Medicaid Act more generally. But taken together, they reinforce the general proposition that the federal government lacks the financial, legal, logistical, and political wherewithal comprehensively to enforce § 30(A) against the states. Thus, whereas the Department of Justice suggests that "Recognition of a nonstatutory cause of action for Medicaid providers and beneficiaries in this setting would be in tension with

the nature of the federal-state relationship and the enforcement scheme contemplated by the statute," Gov't Br., *supra*, at 25, the reality is that *exclusive* federal enforcement would be in far greater tension with the scheme Congress intended and HHS has historically supported and embraced, if for no other reason than that it would not—and probably cannot—produce meaningful compliance with the Medicaid Act's access mandate.

III. PRIVATE ENFORCEMENT OF § 30(A) DOES NOT MATERIALLY INTERFERE WITH THE SECRETARY'S DISCRETION

Separate from the contention that private enforcement would generally be inconsistent with the statutory scheme Congress intended to create in the Medicaid Act, the Justice Department's brief concludes by offering the related but distinct argument that private enforcement of § 30(A) would interfere with the Secretary's authority to administer the Medicaid Act, and, specifically, to approve or reject state plans and amendments thereto. *See, e.g.*, Gov't Br., *supra*, at 32 ("Recognition of a nonstatutory private right of action would mean that multiple federal courts across different jurisdictions would similarly (and perhaps simultaneously) be called on to decide such compliance questions."); *see also id.* ("[T]he proceedings would inevitably lead to the development and application of different legal standards.").

Even if this concern was well-founded (and, as explained below, it is not), the fact remains that private enforcement has been a prominent feature of the Medicaid Act in general, and the equal access provision in particular, since well before this Court's 2002 decision in *Gonzaga University* v. *Doe*, 536 U.S.

275. And in the nine years since *Gonzaga*, neither Congress nor HHS has taken any steps to alter the tandem enforcement structure that emerged during the first 37 years of the program. Thus, it is no surprise that, whatever other critiques such private enforcement may have engendered, the Justice Department can point to no prior instance in which interference with the agency's discretion was invoked to militate against private remedies.

a. The Federal Government Has Never Previously Opposed Private Enforcement of § 30(A) on the Ground That It Would Interfere With the Secretary's Authority

Although it has consistently been HHS's position that private enforcement serves an important role in vindicating the Medicaid Act's central goals, the same view was not always shared by the Justice Department—even prior to this litigation. In *Wilder*, for example, the government's brief as *amicus curiae* (which was not joined by any HHS officials) argued against allowing for private enforcement of the Boren Amendment via 42 U.S.C. § 1983, offering much of the same analysis concerning the nature of the statutory scheme that the *Wilder* Court ultimately rejected (and that the Justice Department's brief in this case largely reprises). *See* Brief for the United States as Amicus Curiae Supporting Petitioners, *Wilder*, 496 U.S. 498 (No. 88-2043).

Tellingly, though, the *Wilder* brief did not suggest that private enforcement of the Boren Amendment would interfere with the *Secretary*'s discretion. Instead, it argued that

> Congress did not intend to confer on Medicaid providers an "enforceable

> right" to challenge state reimbursement decisions in federal court. Lawsuits like respondent's interfere with *state* autonomy and discretion, and they contravene Congress's intent that the degree of federal oversight be minimized. There is no reason to believe that Congress wished the participating States to absorb the substantial costs entailed by such litigation.

Id. at 23 (emphasis added).

Indeed, testifying before the House Commerce Committee in 1996, Secretary Shalala specifically suggested that, rather than interfering with the agency, "[r]eview by federal courts . . . *promotes* efficiency," because it allows for those with principal responsibility for the content of federal law to control its application across multiple jurisdictions, especially "when Medicaid interacts, as is often the case, with other federal statutes (such as Medicare, Social Security, SSI and AFDC)." *NGA Agreement* Hearing, *supra* (statement of Hon. Donna E. Shalala) (emphasis added). These disparate examples reflect the same broader truth, *i.e.*, that the federal government has never previously argued against private enforcement of the Medicaid Act on the ground that such suits would interfere with the Secretary's discretion in administering the statute.

b. Unless Private Enforcement Yields an Unambiguous Construction of § 30(A), the Secretary Retains Discretion Over State Plans

The absence of prior examples, and the thrust of Secretary Shalala's testimony, may perhaps be attributed to the fact that it is difficult to understand

how private enforcement *could* meaningfully interfere with the Secretary's authority. In that regard, the Justice Department's analysis of the potential for interference if the decision below were affirmed appears to neglect settled principles of administrative law.

First, as a general matter, if § 30(A) is ever ambiguous as to what constitutes "equal access," *see, e.g.*, *Alaska Dep't of Health & Soc. Servs.* v. *CMS*, 424 F.3d 931, 935 (9th Cir. 2005), the Secretary's reasonable interpretation of that language will be entitled to *Chevron* deference, *see, e.g.*, *Pharm. Research & Mfrs. of Am.* v. *Thompson*, 362 F.3d 817, 821–22 (D.C. Cir. 2004) ("In the case of the Medicaid payment statute, the Congress expressly conferred on the Secretary authority to review and approve state Medicaid plans as a condition to disbursing federal Medicaid payments. . . . Congress [thereby] manifested its intent that the Secretary's determinations, based on interpretation of the relevant statutory provisions, should have the force of law." (quoting *United States* v. *Mead Corp.*, 533 U.S. 218, 229 (2001)); *see also West Virginia* v. *Thompson*, 475 F.3d 204, 212-13 (4th Cir. 2007) (holding that *Chevron* deference applies to CMS's interpretation of Medicaid Act provision in approval of state plan amendments); *Harris* v. *Olszewski*, 442 F.3d 456, 466–67 (6th Cir. 2006) (same); *S.D. ex rel. Dickson* v. *Hood*, 391 F.3d 581, 595–96 (5th Cir. 2004) (same). *See generally Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994).

Second, because the Secretary's reasonable interpretations of § 30(A) will generally receive *Chevron* deference, she is not bound by prior judicial decisions holding that particular state plan

amendments do or do not violate § 30(A) in cases in which the statute is held to be ambiguous. As this Court has explained, "A court's prior judicial construction of a statute trumps an agency construction otherwise entitled to *Chevron* deference only if the prior court decision holds that its construction follows from the unambiguous terms of the statute and thus leaves no room for agency discretion." *Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 982 (2005); *see also id.* at 982–83 ("Only a judicial precedent holding that the statute unambiguously forecloses the agency's interpretation, and therefore contains no gap for the agency to fill, displaces a conflicting agency construction."). Even if a case arose in which a court construed § 30(A) to be unambiguous, that would only prove the point, for the Secretary at that point would have *no* statutory discretion to approve or reject the state plan amendment there at issue. *See, e.g.*, *Ark. Med. Soc'y*, 6 F.3d at 526 n.5 ("[T]he operative effect of [§ 30(A)] is to underscore the mandatory nature of the state plan requirements by expressly prohibiting the Secretary's discretion to approve funds for state provisions that do not conform to federal law.").

Third, and related, a judicial decision upholding or invalidating a state plan amendment based upon an interpretation of ambiguous language within § 30(A) would not preclude the state from submitting either that amendment or a revised one to the Secretary for approval. *See, e.g.*, *New York* v. *Shalala*, 119 F.3d 175, 180–81 (2d Cir. 1997). Of course, such a possibility does not mean that private enforcement would be meaningless; the effect of the court's decision in such a case would be, critically, to

bar enforcement of the challenged amendment until and unless it is approved by the Secretary. *See, e.g.*, *Exeter* Amicus Br., *supra*, at 7–10 (setting forth as HCFA's position that states assume the risk of private litigation if they implement a plan or plan amendment prior to agency approval). So understood, it is difficult to see how private enforcement could jeopardize the Secretary's discretion before that discretion could even be exercised.

The upshot of these points is that private judicial enforcement of § 30(A) cannot meaningfully interfere with the Secretary's discretion to interpret § 30(A) in approving or rejecting state plan amendments. Where a state plan amendment satisfies or violates the plain text of § 30(A), the Secretary possesses no such discretion. And where the statute *is* ambiguous, the Secretary's reasonable interpretation of whether a state plan amendment complies with § 30(A) will necessarily override any prior judicial interpretation—and control any subsequent judicial consideration—of the same amendment. All that private enforcement adds is the ability (which may well be vital from the beneficiaries' perspective) to enjoin a violation of § 30(A) until and unless the Secretary has the opportunity to act.

c. Private Enforcement Provides a Means for Meaningful Statutory Enforcement Both Until and Unless the Secretary Has the Opportunity To Exercise Her Discretion—and to Ensure that the Secretary is Acting Within Her Discretion

Lest the above discussion suggest that private enforcement is but a temporary stop-gap to preserve the status quo until the agency has the chance

formally to approve or reject a state plan or plan amendment, private enforcement also fills the vital gap that the difficulties identified in Part II, *supra*, would otherwise create: As HHS explained in its amicus brief in the *Exeter* litigation, "even if HCFA decides, in the exercise of its discretion, not to bring a compliance action against a State for implementing a [plan amendment] prior to HCFA approval, . . . the State may still be subject to a suit for injunctive and declaratory relief . . . ." *Exeter* Amicus Br., *supra*, at 10; *see also Planned Parenthood* Amicus Br., *supra* (explaining why injunctive relief prior to HHS rejection of a state plan is both necessary and appropriate).

In other words, in addition to not interfering with the Secretary's discretion, private enforcement may even expand the Secretary's discretion by providing a means of ensuring state compliance with § 30(A) that is far less draconian than the administrative remedies directly available to the Secretary. This understanding has been the cornerstone of HHS policy throughout the history of the Medicaid Act, and the prevailing view of those charged with administering the program. Moreover, the Justice Department's present views to the contrary, such a view is completely consistent with the cause of action recognized by the Court of Appeals. *See Indep. Living Ctr. of S. Cal., Inc.* v. *Shewry*, 543 F.3d 1050 (9th Cir. 2008), *cert. granted sub nom. Maxwell-Jolly* v. *Indep. Living Ctr. of S. Cal., Inc.*, 131 S. Ct. 992 (2011).

CONCLUSION

For the foregoing reasons, *amici* respectfully submit that the decisions below be affirmed.

Respectfully submitted,

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AUGUST 5, 2011

APPENDIX

List of *Amici Curiae* Former HHS Officials

JODIE Z. BERNSTEIN
General Counsel, HHS (1979–81)

HON. JOSEPH A. CALIFANO, JR.
Secretary, U.S. Department of Health, Education, and Welfare (1977–79)

PETER B. EDELMAN
Counselor to the Secretary, HHS (1993–95);
Assistant Secretary for Planning and Evaluation, HHS (1995–96)

JUDITH M. FEDER
Principal Deputy Assistant Secretary for Planning and Evaluation, HHS (1993–95)

NAN D. HUNTER
Deputy General Counsel, HHS (1993–96)

RENÉE M. LANDERS
Acting Deputy General Counsel, HHS (1996);
Deputy General Counsel, HHS (1996–1997)

KAREN POLLITZ
Deputy Assistant Secretary for Health Legislation, HHS (1993–97);
Director, Office of Consumer Support, Center for Consumer Information and Insurance Oversight, CMS (2010–11)

HARRIET S. RABB
General Counsel, HHS (1993–2001)

DAVID SATCHER, M.D., PH.D.
U.S. Surgeon General (1998–2002);
Assistant Secretary for Health (1998–2001)

HON. DONNA E. SHALALA
Secretary, HHS (1993–2001)

BRUCE C. VLADECK
Administrator, HCFA (1993–97)

TIMOTHY M. WESTMORELAND
Director of Center for Medicaid and State
Operations, HCFA (1999–2001)